CYCLOSPORINE - cyclosporine injection, solution
Bedford Laboratories

Rx ONLY
FOR INFUSION ONLY

> **WARNING**
>
> **Only physicians experienced in immunosuppressive therapy and management of organ transplant patients should prescribe cyclosporine. Patients receiving the drug should be managed in facilities equipped and staffed with adequate laboratory and supportive medical resources. The physician responsible for maintenance therapy should have complete information requisite for the follow-up of the patient.**
> **Cyclosporine should be administered with adrenal corticosteroids but not with other immunosuppressive agents. Increased susceptibility to infection and the possible development of lymphoma may result from immunosuppression.**

DESCRIPTION

Cyclosporine is a cyclic polypeptide immunosuppressant agent consisting of 11 amino acids. It is produced as a metabolite by the fungus species *Fusarium solari*. Chemically, cyclosporine is designated as [R-[R*,R*-(E)]]-Cyclic(L-alanyl-D-alanyl-N-methyl-L-leucyl-N-methyl-L-leucyl-N-methyl-L-valyl-3-hydroxy-N,4-dimethyl-L-2-amino-6-octenoyl-L-α-aminobutyryl-N-methylglycyl-N-methyl-L-leucyl-L-valyl-N-methyl-L-leucyl).

Each mL contains cyclosporine, USP 50 mg; polyoxyethylated castor oil 650 mg; absolute alcohol 33.2% (v/v) and water for injection, q.s. Cyclosporine Injection, USP is for intravenous infusion only and must be diluted further with 0.9% Sodium Chloride Injection or 5% Dextrose Injection before use.

The structural formula is as follows:
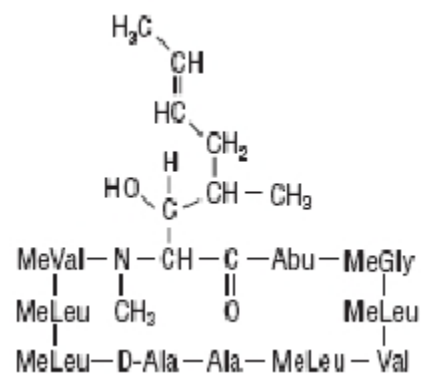
Molecular Formula: $C_{62}H_{111}N_{11}O_{12}$
M.W. =1202.64

CLINICAL PHARMACOLOGY

Cyclosporine is a potent immunosuppressive agent which in animals prolongs survival of allogeneic transplants involving skin, heart, kidney, pancreas, bone marrow, small intestine, and lung. Cyclosporine has been demonstrated to suppress some humoral immunity and to a greater extent, cell-mediated reactions such as allograft rejection, delayed hypersensitivity, experimental allergic encephalomyelitis, Freund's adjuvant arthritis, and graft vs. host disease in many animal species for a variety of organs.

Successful kidney, liver, and heart allogeneic transplants have been performed in man using cyclosporine.

The exact mechanism of action of cyclosporine is not known. Experimental evidence suggests that the effectiveness of cyclosporine is due to specific and reversible inhibition of immunocompetent lymphocytes in the G_0- or G_1-phase of the cell cycle. T-lymphocytes are preferentially inhibited. The T-helper cell is the main target, although the T-suppressor cell may also be suppressed. Cyclosporine also inhibits lymphokine production and release including interleukin-2 or T-cell growth factor (TCGF).

No functional effects on phagocytic (changes in enzyme secretions not altered, chemotactic migration of granulocytes, macrophage migration, carbon clearance *in vivo*) or tumor cells (growth rate, metastasis) can be detected in animals. Cyclosporine does not cause bone marrow suppression in animal models or man.

The absorption of cyclosporine from the gastrointestinal tract is incomplete and variable. Peak concentrations (C_{max}) in blood and plasma are achieved at about 3.5 hours. C_{max} and area under the plasma or blood concentration/time curve (AUC) increase with the administered dose; for blood the relationship is curvilinear (parabolic) between 0 and 1400 mg. As determined by a specific assay, C_{max} is approximately 1 ng/mL/mg of dose for plasma and 2.7 to 1.4 ng/mL/mg of dose for blood (for low to high doses).

Cyclosporine is distributed largely outside the blood volume. In blood the distribution is concentration dependent. Approximately 33% to 47% is in plasma, 4% to 9% in lymphocytes, 5% to 12% in granulocytes, and 41% to 58% in erythrocytes. At high concentrations,

the uptake by leukocytes and erythrocytes becomes saturated. In plasma, approximately 90% is bound to proteins, primarily lipoproteins.

The disposition of cyclosporine from blood is biphasic with a terminal half-life of approximately 19 hours (range: 10 to 27 hours). Elimination is primarily biliary with only 6% of the dose excreted in the urine.

Cyclosporine is extensively metabolized but there is no major metabolic pathway. Only 0.1% of the dose is excreted in the urine as unchanged drug. Of 15 metabolites characterized in human urine, 9 have been assigned structures. The major pathways consist of hydroxylation of the Cγ-carbon of 2 of the leucine residues, Cη-carbon hydroxylation, and cyclic ether formation (with oxidation of the double bond) in the side chain of the amino acid 3-hydroxyl-*N*,4-dimethyl-L-2-amino-6-octenoic acid and *N*-demethylation of *N*-methyl leucine residues. Hydrolysis of the cyclic peptide chain or conjugation of the aforementioned metabolites do not appear to be important biotransformation pathways.

INDICATIONS AND USAGE

Cyclosporine is indicated for the prophylaxis of organ rejection in kidney, liver, and heart allogeneic transplants. It is always to be used with adrenal corticosteroids. The drug may also be used in the treatment of chronic rejection in patients previously treated with other immunosuppressive agents.

Because of the risk of anaphylaxis, cyclosporine injection should be reserved for patients who are unable to take the soft gelatin capsules or oral solution.

CONTRAINDICATIONS

Cyclosporine is contraindicated in patients with a hypersensitivity to cyclosporine and/or polyoxyethylated castor oil.

WARNINGS

(See boxed **WARNING**.)

Cyclosporine, when used in high doses, can cause hepatotoxicity and nephrotoxicity.

It is not unusual for serum creatinine and BUN levels to be elevated during cyclosporine therapy. These elevations in renal transplant patients do not necessarily indicate rejection, and each patient must be fully evaluated before dosage adjustment is initiated.

Nephrotoxicity has been noted in 25% of cases of renal transplantation, 38% of cases of cardiac transplantation, and 37% of cases of liver transplantation. Mild nephrotoxicity was generally noted 2 to 3 months after transplant and consisted of an arrest in the fall of the preoperative elevation of BUN and creatinine at a range of 35 to 45 mg/dL and 2 to 2.5 mg/dL respectively. These elevations were often responsive to dosage reduction.

More overt nephrotoxicity was seen early after transplantation and was characterized by a rapidly rising BUN and creatinine. Since these events are similar to rejection episodes care must be taken to differentiate between them. This form of nephrotoxicity is usually responsive to cyclosporine dosage reduction.

Although specific diagnostic criteria which reliably differentiate renal graft rejection from drug toxicity have not been found, a number of parameters have been significantly associated to one or the other. It should be noted, however, that up to 20% of patients may have simultaneous nephrotoxicity and rejection.

Nephrotoxicity vs Rejection

Parameter	Nephrotoxicity	Rejection
History	Donor > 50 years old or hypotensive Prolonged kidney preservation Prolonged anastomosis time Concomitant nephrotoxic drugs	Antidonor immune response Retransplant patient
Clinical	Often > 6 weeks postop[b] Prolonged initial nonfunction (acute tubular necrosis	Often < 4 weeks postop[b] Fever > 37.5°C Weight gain > 0.5 kg Graft swelling and tenderness Decrease in daily urine volume > 500 mL (or 50%)
Laboratory	CyA serum trough level > 200 ng/mL Gradual rise in Cr (<0.15 mg/dL/day)[a] Cr plateau < 25% above baseline Cr > 25% above baseline[a] BUN/Cr ≥ 20	CyA serum trough level < 150 ng/mL Rapid rise in Cr (> 0.3 mg/dL/day)[a] BUN/Cr < 20
Biopsy	Arteriolopathy (medial hypertrophy[a], hyalinosis, nodular deposits, intimal thickening, endothelial vacuolization, progressive scarring)	Endovasculitis[c] (proliferation[a], intimal arteritis[b], necrosis, sclerosis)

	Tubular atrophy, isometric vacuolization, isolated calcifications Minimal edema Mild focal infiltrates[c] Diffuse interstitial fibrosis, often striped form	Tubulitis with RBC[b] and WBC[b] casts, some irregular vacuolization Interstital edema[c] and hemorrhage[b] Diffuse moderate to severe mononuclear infiltrates[d] Glomerulitis (mononuclear cells)[c]
Aspiration Cytology	CyA deposits in tubular and endothelial cells Fine isometric vacuolization of tubular cells	Inflammatory infiltrate with mononuclear phagocytes, macrophages, lymphoblastoid cells, and activated T-cells These strongly express HLA-DR antigens
Urine Cytology	Tubular cells with vacuolization and granularization	Degenerative tubular cells, plasma cells, and lymphocyturia > 20% of sediment
Manometry	Intracapsular pressure < 40 mm Hg[b]	Intracapsular pressure > 40 mm Hg[b]
Ultrasonography	Unchanged graft cross-sectional area	Increase in graft cross-sectional areaAP diameter ≥ Transverse diameter
Magnetic Resonance Imagery	Normal appearance	Loss of distinct corticomedullary junction, swelling, image intensity of parachyma approaching that of psoas, loss of hilar fat
Radionuclide Scan	Normal or generally decreased perfusion Decrease in tubular function (^{131}I-hippuran) > decrease in perfusion (^{99m}Tc DTPA)	Patchy arterial flow Decrease in perfusion > decrease in tubular function Increased uptake of Indium 111 labeled platelets or Tc-99m in colloid
Therapy	Responds to decreased cyclosporine	Responds to increased steroids or antilymphocyte globulin

[a]$p < 0.05$, [b]$p < 0.01$, [c]$p < 0.001$, [d]$p < 0.0001$

A form of chronic progressive cyclosporine-associated nephrotoxicity is characterized by serial deterioration in renal function and morphologic changes in the kidneys. From 5% to 15% of transplant recipients will fail to show a reduction in a rising serum creatinine despite a decrease or discontinuation of cyclosporine therapy. Renal biopsies from these patients will demonstrate an interstitial fibrosis with tubular atrophy. In addition, toxic tubulopathy, peritubular capillary congestion, arteriolopathy, and a striped form of interstitial fibrosis with tubular atrophy may be present. Though none of these morphologic changes is entirely specific, a histologic diagnosis of chronic progressive cyclosporine-associated nephrotoxicity requires evidence of these.

When considering the development of chronic nephrotoxicity it is noteworthy that several authors have reported an association between the appearance of interstitial fibrosis and higher cumulative doses or persistently high circulating trough levels of cyclosporine. This is particularly true during the first 6 posttransplant months when the dosage tends to be highest and when, in kidney recipients, the organ appears to be most vulnerable to the toxic effects of cyclosporine. Among other contributing factors to the development of interstitial fibrosis in these patients must be included, prolonged perfusion time, warm ischemia time, as well as episodes of acute toxicity, and acute and chronic rejection. The reversibility of interstitial fibrosis and its correlation to renal function have not yet been determined.

Impaired renal function at any time requires close monitoring, and frequent dosage adjustment may be indicated. In patients with persistent high elevations of BUN and creatinine who are unresponsive to dosage adjustments, consideration should be given to switching to other immunosuppressive therapy. In the event of severe and unremitting rejection, it is preferable to allow the kidney transplant to be rejected and removed rather than increase the cyclosporine dosage to a very high level in an attempt to reverse the rejection.

Occasionally patients have developed a syndrome of thrombocytopenia and microangiopathic hemolytic anemia which may result in graft failure. The vasculopathy can occur in the absence of rejection and is accompanied by avid platelet consumption within the graft as demonstrated by Indium 111 labeled platelet studies. Neither the pathogenesis nor the management of this syndrome is clear. Though resolution has occurred after reduction or discontinuation of cyclosporine and 1) administration of streptokinase and heparin or 2) plasmapheresis, this appears to depend upon early detection with Indium 111 labeled platelet scans. (See **ADVERSE REACTIONS**.)

Significant hyperkalemia (sometimes associated with hyperchloremic metabolic acidosis) and hyperuricemia have been seen occasionally in individual patients.

Hepatotoxicity has been noted in 4% of cases of renal transplantation, 7% of cases of cardiac transplantation, and 4% of cases of liver transplantation. This was usually noted during the first month of therapy when high doses of cyclosporine were used and consisted of elevations of hepatic enzymes and bilirubin. The chemistry elevations usually decreased with a reduction in dosage.

As in patients receiving other immunosuppressants, those patients receiving cyclosporine are at increased risk for development of lymphomas and other malignancies, particularly those of the skin. The increased risk appears related to the intensity and duration of immunosuppression rather than to the use of specific agents. Because of the danger of oversuppression of the immune system, which can also increase susceptibility to infection, cyclosporine should not be administered with other immunosuppressive agents except adrenal corticosteroids. The efficacy and safety of cyclosporine in combination with other immunosuppressive agents have not been determined.

There have been reports of convulsions in adult and pediatric patients receiving cyclosporine, particularly in combination with high dose methylprednisolone.

Encephalopathy has been described both in post-marketing reports and in the literature. Manifestations include impaired consciousness, convulsions, visual disturbances (including blindness), loss of motor function, movement disorders and psychiatric disturbances. In many cases, changes in the white matter have been detected using imaging techniques and pathologic specimens. Predisposing factors such as hypertension, hypomagnesemia, hypocholesterolemia, highdose corticosteriods, high cyclosporine blood concentrations, and graft-versus-host disease have been noted in many but not all of the reported cases. The changes in most cases have been reversible upon discontinuation of cyclosporine, and in some cases improvement was noted after reduction of dose. It appears that patients receiving liver transplant are more susceptible to encephalopathy than those patients receiving kidney transplant. Another rare manifestation of cyclosporine-induced neurotoxicity is optic disc edema including papilloedema, with possible visual impairment, secondary to benign intracranial hypertension.

Rarely (approximately 1 in 1000), patients receiving cyclosporine injection have experienced anaphylactic reactions. Although the exact cause of these reactions is unknown, it is believed to be due to the polyoxyethylated castor oil used as the vehicle for the I.V. formulation. These reactions can consist of flushing of the face and upper thorax, and non-cardiogenic pulmonary edema, with acute repiratory distress, dyspnea, wheezing, blood pressure changes, and tachycardia. One patient died after respiratory arrest and aspiration pneumonia. In some cases, the reaction subsided after the infusion was stopped.

Patients receiving cyclosporine injection should be under continuous observation for at leastthe first 30 minutes following the start of the infusion and at frequent intervals thereafter. If anaphylaxis occurs, the infusion should be stopped. An aqueous solution of epinephrine 1:1000 should be available at the bedside as well as a source of oxygen.

Anaphylactic reactions have not been reported with the soft gelatin capsules or oral solution which lack polyoxyethylated castor oil. In fact, patients experiencing anaphylactic reactions have been treated subsequently with the soft gelatin capsules or oral solution without incident.

Care should be taken in using cyclosporine with nephrotoxic drugs. (See **PRECAUTIONS**.)

Because Cyclosporine Injection is not bioequivalent to Neoral®, conversion from Neoral® to Cyclosporine Injection using a 1:1 ratio (mg/kg/day) may result in a lower cyclosporine blood concentration. Conversion from Neoral® to Cyclosporine Injection should be made with increased blood concentration monitoring to avoid the potential of underdosing.

PRECAUTIONS

General

Hypertension is a common side effect of cyclosporine therapy. (See **ADVERSE REACTIONS**.) Mild or moderate hypertension is more frequently encountered than severe hypertension and the incidence decreases over time. Antihypertensive therapy may be required. Control of blood pressure can be accomplished with any of the common antihypertensive agents. However, since cyclosporine may cause hyperkalemia, potassium-sparing diuretics should not be used. While calcium antagonists can be effective agents in treating cyclosporine-associated hypertension, care should be taken since interference with cyclosporine metabolism may require a dosage adjustment. (See **Drug interactions**.)

During treatment with cyclosporine, vaccination may be less effective; and the use of live attenuated vaccines should be avoided.

Information for patients

Patients should be advised that any change of cyclosporine formulation should be made cautiously and only under physician supervision because it may result in the need for a change in dosage.

Patients should be informed of the necessity of repeated laboratory tests while they are receiving the drug. They should be given careful dosage instructions, advised of the potential risks during pregnancy, and informed of the increased risk of neoplasia.

Laboratory tests

Renal and liver functions should be assessed repeatedly by measurement of BUN, serum creatinine, serum bilirubin, and liver enzymes.

Interactions

Drug interactions

All of the individual drugs cited below are well substantiated to interact with cyclosporine. In addition, concomitant non-steroidal anti-inflammatory drugs, particularly in the setting of dehydration, may potentiate renal dysfunction.

Drugs That May Potentiate Renal Dysfunction

Antibiotics	ciprofloxacin, gentamicin, tobramycin, vancomycin, trimethoprim with sulfamethoxazole
Antineoplastics	melphalan
Antifungals	amphotericin B, ketoconazole
Anti-Inflammatory Drugs	azapropazon, colchicine, diclofenac, naproxen, sulindac
Gastrointestinal Agents	cimetidine, ranitidine
Immunosuppressives	tacrolimus
Other Drugs	fibric acid derivatives (e.g., bezafibrate, fenofibrate)

Drugs That Alter Cyclosporine Concentrations:
Compounds that decrease cyclosporine absorption such as orlistat should be avoided. Cyclosporine is extensively metabolized by cytochrome P-450 3A. Substances that inhibit this enzyme could decrease metabolism and increase cyclosporine concentrations. Substances that are inducers of cytochrome P-450 activity could increase metabolism and decrease cyclosporine concentrations. Monitoring of circulating cyclosporine concentrations and appropriate cyclosporine dosage adjustment are essential when these drugs are used concomitantly. (See **Blood Level Monitoring.**)

Drugs That Increase Cyclosporine Concentrations

Antibiotics	azithromycin, clarithromycin, erythromycin, quinupristin/dalfopristin
Antifungals	fluconazole, itraconazole, ketoconazole
Calcium Channel Blockers	diltiazem, nicardipine, verapamil
Glucocorticoids	methylprednisolone
Other Drugs	allopurinol, amiodarone, bromocriptine, colchicine, danazol, metoclopromide, imatinib, oral contraceptives

The HIV protease inhibitors (e.g., indinavir, nelfinavir, ritonavir, and saquinavir) are known to inhibit cytochrome P-450 3A and thus could potentially increase the concentrations of cyclosporine; however, no formal studies of the interaction are available. Care should be exercised when these drugs are administered concomitantly.

Grapefruit and grapefruit juice affect metabolism, increasing blood concentrations of cyclosporine, thus should be avoided.

Drugs/Dietary Supplements That Decrease Cyclosporine Concentrations

Antibiotics	Nafcillin, rifampin
Anticonvulsants	Carbamazepine, phenobarbital, phenytoin
Other Drugs/Dietary Supplements	Octreotide, orlistat, sulfinpyrazone, terbinafine, ticlopidine, St. John's Wort

There have been reports of a serious drug interaction between cyclosporine and the herbal dietary supplement, St. John's Wort. This interaction has been reported to produce a marked reduction in the blood concentrations of cyclosporine, resulting in subtherapeutic levels, rejection of transplanted organs, and graft loss.

Rifabutin is known to increase the metabolism of other drugs metabolized by the cytochrome P-450 system. The interaction between rifabutin and cyclosporine has not been studied. Care should be exercised when these two drugs are administered concomitantly.

Nonsteroidal Anti-inflammatory Drug (NSAID) Interactions: Clinical status and serum creatinine should be closely monitored when cyclosporine is used with nonsteroidal anti-inflammatory agents in rheumatoid arthritis patients. (See **WARNINGS**.)

Pharmacodynamic interactions have been reported to occur between cyclosporine and both naproxen and sulindac, in that concomitant use is associated with additive decreases in renal function, as determined by ^{99m}Tc-diethylenetriaminepentaacetic acid (DTPA) and (p-aminohippuric acid) PAH clearances. Although concomitant administration of diclofenac does not affect blood levels of cyclosporine, it has been associated with approximate doubling of diclofenac blood levels and occasional reports of reversible decreases in renal function. Consequently, the dose of diclofenac should be in the lower end of the therapeutic range.

Methotrexate Interaction: Preliminary data indicate that when methotrexate and cyclosporine were co-administered to rheumatoid arthritis patients (N=20), methotrexate concentrations (AUCs) were increased approximately 30% and the concentrations (AUCs) of its metabolite, 7-hydroxy methotrexate, were decreased by approximately 80%. The clinical significance of this interaction is not known. Cyclosporine concentrations do not appear to have been altered (N=6).

Other Drug Interactions: Cyclosporine may reduce the clearance of digoxin, colchicine, prednisolone and HMG-CoA reductase inhibitors (statins). Severe digitalis toxicity has been seen within days of starting cyclosporine in several patients taking digoxin.

There are also reports on the potential of cyclosporine to enhance the toxic effects of colchicine such as myopathy and neuropathy, especially in patients with renal dysfunction. If digoxin or colchicine are used concurrently with cyclosporine, close clinical observation is required in order to enable early detection of toxic manifestations of digoxin or colchicine, followed by reduction of dosage and its withdrawal.

Literature and postmarketing cases of myotoxicity, including muscle pain and weakness, myositis, and rhabdomyolysis, have been reported with concomitant administration of cyclosporine with lovastatin, simvastatin, atorvastatin, pravastatin, and, rarely, fluvastatin. When concurrently administered with cyclosporine, the dosage of these statins should be reduced according to label recommendations. Statin therapy needs to be temporarily withheld or discontinued in patients with signs and symptoms of myopathy or those with risk factors predisposing to severe renal injury, including renal failure, secondary to rhabdomyolysis.

Cyclosporine should not be used with potassium-sparing diuretics because hyperkalemia can occur. Caution is also required when cyclosporine is co-administered with potassium sparing drugs (e.g., angiotensin converting enzyme inhibitors, angiotensin II receptor antagonists), potassium containing drugs as well as in patients on a potassium rich diet. Control of potassium levels in these situations is advisable.

Elevations in serum creatinine were observed in studies using sirolimus in combination with full-dose cyclosporine. This effect is often reversible with cyclosporine dose reduction.

Simultaneous co-administration of cyclosporine significantly increases blood levels of sirolimus. To minimize increases in sirolimus blood concentrations, it is recommended that sirolimus be given 4 hours after cyclosporine administration.

During treatment with cyclosporine, vaccination may be less effective. The use of live vaccines should be avoided. Frequent gingival hyperplasia with nifedipine, and convulsions with high dose methylprednisolone have been reported.

Psoriasis patients receiving other immunosuppressive agents or radiation therapy (including PUVA and UVB) should not receive concurrent cyclosporine because of the possibility of excessive immunosuppression.

Carcinogenesis, mutagenesis, impairment of fertility
Cyclosporine gave no evidence of mutagenic or teratogenic effects in appropriate test systems.Only at dose levels toxic to dams, were adverse effects seen in reproduction studies in rats. (See **Pregnancy**.)
Carcinogenicity studies were carried out in male and female rats and mice. In the 78-week mouse study, at doses of 1, 4, and 16 mg/kg/day, evidence of a statistically significant trend was found for lymphocytic lymphomas in females, and the incidence of hepatocellular carcinomas in mid-dose males significantly exceeded the control value. In the 24-month rat study, conducted at 0.5, 2, and 8 mg/kg/day, pancreatic islet cell adenomas significantly exceeded the control rate in the low dose level. The hepatocellular carcinomas and pancreatic islet cell adenomas were not dose related.
No impairment in fertility was demonstrated in studies in male and female rats.
Cyclosporine has not been found mutagenic/genotoxic in the Ames Test, the V79-HGPRT Test, the micronucleus test in mice and Chinese hamsters, the chromosome-aberration tests in Chinese hamster bone-marrow, the mouse dominant lethal assay, and the DNA-repair test in sperm from treated mice. A recent study analyzing sister chromatid exchange (SCE) induction by cyclosporine using human lymphocytes *in vitro* gave indication of a positive effect (i.e., induction of SCE), at high concentrations in this system. In two published research studies, rabbits exposed to cyclosporine in utero (10 mg/kg/day subcutaneously) demonstrated reduced numbers of nephrons, renal hypertrophy, systemic hypertension and progressive renal insufficiency up to 35 weeks of age. Pregnant rats which received 12 mg/kg/day of cyclosporine intravenously (twice the recommended human intravenous dose) had fetuses with an increase incidence of ventricular septal defect. These findings have not been demonstrated in other species and their relevance for humans is unknown.
An increased incidence of malignancy is a recognized complication of immunosuppression in recipients of organ transplants. The most common forms of neoplasms are non-Hodgkin's lymphoma and carcinomas of the skin. The risk of malignancies in cyclosporine recipients is higher than in the normal, healthy population but similar to that in patients receiving other immunosuppressive therapies. It has been reported that reduction or discontinuance of immunosuppression may cause the lesions to regress.

Pregnancy

Teratogenic effects
Pregnancy Category C

Animal studies have shown reproductive toxicity in rats and rabbits. Cyclosporine gave no evidence of mutagenic or teratogenic effects in the standard test systems with oral application (rats up to 17 mg/kg and rabbits up to 30 mg/kg per day orally).

Cyclosporine oral solution has been shown to be embryo- and fetotoxic in rats and rabbits when given in doses 2 to 5 times the human dose. At toxic doses (rats at 30 mg/kg/day and rabbits at 100 mg/kg/day), cyclosporine oral solution was embryo- and fetotoxic as

indicated by increased pre- and postnatal mortality and reduced fetal weight together with related skeletal retardations. In the well-tolerated dose range (rats at up to 17 mg/kg/day and rabbits at up to 30 mg/kg/day), cyclosporine oral solution proved to be without any embryolethal or teratogenic effects.

There are no adequate and well-controlled studies in pregnant women and, therefore, cyclosporine should not be used during pregnancy unless the potential benefit to the mother justifies the potential risk to the fetus.

In pregnant transplant recipients who are being treated with immunosuppressants, the risk of premature births is increased. The following data represent the reported outcomes of 116 pregnancies in women receiving cyclosporine during pregnancy, 90% of whom were transplant patients, and most of whom received cyclosporine throughout the entire gestational period. Since most of the patients were not prospectively identified, the results are likely to be biased toward negative outcomes. The only consistent patterns of abnormality were premature birth (gestational period of 28 to 36 weeks) and low birth weight for gestational age. It is not possible to separate the effects of cyclosporine on these pregnancies from the effects of the other immunosuppressants, the underlying maternal disorders, or other aspects of the transplantation milieu. Sixteen fetal losses occurred. Most of the pregnancies (85 of 100) were complicated by disorders; including, preeclampsia, eclampsia, premature labor, abruptio placentae, oligohydramnios, Rh incompatibility and fetoplacental dysfunction. Preterm delivery occurred in 47%. Seven malformations were reported in 5 viable infants and in 2 cases of fetal loss. Twenty-eight percent of the infants were small for gestational age. Neonatal complications occurred in 27%. In a report of 23 children followed up to 4 years, postnatal development was said to be normal. A limited number of observations in children exposed to cyclosporine *in utero* is available, up to an age of approximately 7 years. Renal function and blood pressure in these children were normal.

Nursing mothers
Cyclosporine passes into breast milk. Mothers receiving treatment with cyclosporine should not breast feed.

Pediatric use
Although no adequate and well-controlled studies have been conducted in children, patients as young as 6 months of age have received the drug with no unusual adverse effects.

Geriatric use
Clinical studies of cyclosporine did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger patients. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for the elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

ADVERSE REACTIONS
The principal adverse reactions of cyclosporine therapy are renal dysfunction, tremor, hirsutism, hypertension, and gum hyperplasia. Hypertension, which is usually mild to moderate, may occur in approximately 50% of patients following renal transplantation and in most cardiac transplant patients.

Glomerular capillary thrombosis has been found in patients treated with cyclosporine and may progress to graft failure. The pathologic changes resemble those seen in the hemolytic-uremic syndrome and include thrombosis of the renal microvasculature, with platelet-fibrin thrombi occluding glomerular capillaries and afferent arterioles, microangiopathic hemolytic anemia, thrombocytopenia, and decreased renal function. Similar findings have been observed when other immunosuppressives have been employed posttransplantation.

Hypomagnesemia has been reported in some, but not all, patients exhibiting convulsions while on cyclosporine therapy. Although magnesium-depletion studies in normal subjects suggest that hypomagnesemia is associated with neurologic disorders, multiple factors, including hypertension, high dose methylprednisolone, hypocholesterolemia, and nephrotoxicity associated with high plasma concentrations of cyclosporine appear to be related to the neurological manifestations of cyclosporine toxicity.

The following reactions occurred in 3% or greater of 892 patients involved in clinical trials of kidney, heart, and liver transplants:

| Body System/Adverse Reactions | Randomized Kidney Patients | | All Cyclosporine Patients | | |
	Cyclosporine (N=227) %	Azathioprine (N=228) %	Kidney (N=705) %	Heart (N=112) %	Liver (N=75) %
Genitourinary					
Renal Dysfunction	32	6	25	38	37
Cardiovascular					
Hypertension	26	18	13	53	27
Cramps	4	<1	2	<1	0

Skin					
Hirsutism	21	<1	21	28	45
Acne	6	8	2	2	1
Central Nervous System					
Tremor	12	0	21	31	55
Convulsions	3	1	1	4	5
Headache	2	<1	2	15	4
Gastrointestinal					
Gum Hyperplasia	4	0	9	5	16
Diarrhea	3	<1	3	4	8
Nausea/Vomiting	2	<1	4	10	4
Hepatotoxicity	<1	<1	4	7	4
Abdominal Discomfort	<1	0	<1	7	0
Autonomic Nervous System					
Paresthesia	3	0	1	2	1
Flushing	<1	0	4	0	4
Hematopoietic					
Leukopenia	2	19	<1	6	0
Lymphoma	<1	0	1	6	1
Respiratory					
Sinusitis	<1	0	4	3	7
Miscellaneous					
Gynecomastia	<1	0	<1	4	3

The following reactions occurred in 2% or less of patients: allergic reactions, anemia, anorexia, confusion, conjunctivitis, edema, fever, brittle fingernails, gastritis, hearing loss, hiccups, hyperglycemia, muscle pain, peptic ulcer, thrombocytopenia, tinnitus.
The following reactions occurred rarely: anxiety, chest pain, constipation, depression, hair breaking, hematuria, joint pain, lethargy, mouth sores, myocardial infarction, night sweats, pancreatitis, pruritus, swallowing difficulty, tingling, upper GI bleeding, visual disturbance, weakness, weight loss.

Renal Transplant Patients in Whom Therapy Was Discontinued

	Randomized Patients		All Cyclosporine Patients
Reason for Discontinuation	**Cyclosporine (N=227) %**	**Azathioprine (N=228) %**	**(N=705) %**
Renal Toxicity	5.7	0	5.4
Infection	0	0.4	0.9
Lack of Efficacy	2.6	0.9	1.4
Acute Tubular Necrosis	2.6	0	1.0
Lymphoma/Lymphoproliferative Disease	0.4	0	0.3
Hypertension	0	0	0.3
Hematological Abnormalities	0	0.4	0
Other	0	0	0.7

Cyclosporine was discontinued on a temporary basis and then restarted in 18 additional patients.

Infectious Complications in the Randomized Renal Transplant Patients

Complication	Cyclosporine Treatment (N=227) % of Complications	Standard Treatment* (N=228) % of Complications
Septicemia	5.3	4.8
Abscesses	4.4	5.3

Systemic Fungal Infection	2.2	3.9
Local Fungal Infection	7.5	9.6
Cytomegalovirus	4.8	12.3
Other Viral Infections	15.9	18.4
Urinary Tract Infections	21.1	20.2
Wound and Skin Infections	7.0	10.1
Pneumonia	6.2	9.2

*Some patients also received ALG.

Polyoxyethylated castor oil is known to cause hyperlipemia and electrophoretic abnormalities of lipoproteins. These effects are reversible upon discontinuation of treatment but are usually not a reason to stop treatment.

OVERDOSAGE

There is minimal experience with overdosage. Transient hepatotoxicity and nephrotoxicity may occur which should resolve following drug withdrawal. General supportive measures and symptomatic treatment should be followed in all cases of overdosage. Cyclosporine is not dialyzable to any great extent, nor is it cleared well by charcoal hemoperfusion. The I.V. LD_{50} is 148 mg/kg in mice, 104 mg/kg in rats, and 46 mg/kg in rabbits.

DOSAGE AND ADMINISTRATION
FOR INFUSION ONLY

Note: Anaphylactic reactions have occurred with cyclosporine injection. (See **WARNINGS**.)

Patients unable to take cyclosporine soft gelatin capsules or oral solution pre- or postoperatively may be treated with the I.V. concentrate. **Cyclosporine concentrate for injection is administered at 1/3 the oral dose.** The initial dose of cyclosporine concentrate for injection should be given 4 to 12 hours prior to transplantation as a single I.V. dose of 5 to 6 mg/kg/day. This daily single dose is continued postoperatively until the patient can tolerate the soft gelatin capsules or oral solution. Patients should be switched to soft gelatin capsules or oral solution as soon as possible after surgery. In pediatric usage, the same dose and dosing regimen may be used, although higher doses may be required.

Adjunct therapy with adrenal corticosteroids is recommended. Different tapering dosage schedules of prednisone appear to achieve similar results. A dosage schedule based on the patient's weight started with 2 mg/kg/day for the first 4 days tapered to 1 mg/kg/day by 1 week, 0.6 mg/kg/day by 2 weeks, 0.3 mg/kg/day by 1 month, and 0.15 mg/kg/day by 2 months and thereafter as a maintenance dose. Another center started with an initial dose of 200 mg tapered by 40 mg/day until reaching 20 mg/day. After 2 months at this dose, a further reduction to 10 mg/day was made. Adjustments in dosage of prednisone must be made according to the clinical situation.

Immediately before use, the I.V. concentrate should be diluted 1 mL cyclosporine injection in 20 mL to 100 mL 0.9% Sodium Chloride Injection or 5% Dextrose Injection and given in a slow intravenous infusion over approximately 2 to 6 hours. Diluted infusion solutions should be discarded after 24 hours.

The polyoxyethylated castor oil contained in the concentrate for intravenous infusion can cause phthalate stripping from PVC. Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit.

Blood Level Monitoring

Several study centers have found blood level monitoring of cyclosporine useful in patient management. While no fixed relationships have yet been established, in one series of 375 consecutive cadaveric renal transplant recipients, dosage was adjusted to achieve specific whole blood 24-hour trough levels of 100 to 200 ng/mL as determined by high-pressure liquid chromatography (HPLC). Of major importance to blood level analysis is the type of assay used. The above levels are specific to the parent cyclosporine molecule and correlate directly to the new monoclonal specific radioimmunoassays (mRIA-sp). Nonspecific assays are also available which detect the parent compound molecule and various of its metabolites. Older studies often cited levels using a nonspecific assay which were roughly twice those of specific assays. Assay results are not interchangeable and their use should be guided by their approved labeling. If plasma specimens are employed, levels will vary with the temperature at the time of separation from whole blood. Plasma levels may range from 1/2 to 1/5 of whole blood levels. Refer to individual assay labeling for complete instructions. In addition, *Transplantation Proceedings* (June 1990) contains position papers and a broad consensus generated at the Cyclosporine-Therapeutic Drug Monitoring conference that year. Blood level monitoring is not a replacement for renal function monitoring or tissue biopsies.

HOW SUPPLIED

Cyclosporine Injection, USP is supplied in 5 mL sterile single-use vials containing 50 mg of cyclosporine per mL, in cartons of 10. **NDC 55390-122-10.**

Store at 20° to 25°C (68° to 77°F). [See USP Controlled Room Temperature.] **Protect from light.**

Discard unused portion.